EliteCare
HOME HEALTH AGENCY, INC.
533 Airport Blvd. STE 315 Burlingame, CA 94010
Office: 650-273-1184
Fax: 650-273-0313

REFERRAL FAX FORM

Start of Care Requested: ______________________ Referral Date: ______________________

PATIENT INFORMATION

Name: ____ Phone: ____________________________________

SSN: ____________-____________-____________ DOB: ______________________________________

Address: ____

Is the patient being treated for an accident-related injury? ☐ **Yes** ☐ **No**

INSURANCE: ☐ Medicare # ______________________ ☐ HPSM Care Advantage # ______________________

☐ Brand New Day Member ID #____________________ ☐ Imperial Health # _____________________________

☐ Private Pay ☐ Worker's Compensation

DIAGNOSIS: CHF __________ CAD __________ DM __________ HTN __________ AFIB __________

COPD __________ CRF/HD __________ Dementia __________ CVA/TIA __________

Others: ____

Physician Appointment for Patient / Face to face date: ____
Note: A patient must be seen by PCP within 30 days after or no more than 90 days before the referral.

Physician Name: ____________________________ **Signature:** ____________________________________

Physician NPI: ______________________________ **Date:** ____

SERVICES REQUESTED: ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy

☐ Medical Social Worker ☐ Home Health Aide

Counties Covered: Alameda, San Francisco, San Mateo, Santa Clara